House of Representatives

General Assembly

File No. 333

February Session, 2000

House Bill No. 5532

House of Representatives, March 30, 2000

The Committee on Human Services reported through REP. GERRATANA of the 23rd Dist., Chairperson of the Committee on the part of the House, that the bill ought to pass.

An Act Reinstating Medicaid Funding For Dually-Eligible Patients.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (b) of section 17b-265 of the general statutes is repealed and the following is substituted in lieu thereof:

(b) When a recipient of medical assistance has personal health insurance in force covering care or other benefits provided under such program, payment or part-payment of the premium for such insurance may be made when deemed appropriate by the Commissioner of Social Services. **[**Effective January 1, 1992, the commissioner shall limit reimbursement to medical assistance providers, except those providers whose rates are established by the Commissioner of Public Health pursuant to chapter 368d, for coinsurance and deductible payments under Title XVIII of the Social Security Act to assure that the combined Medicare and Medicaid payment to the provider shall not exceed the maximum allowable under the Medicaid program fee schedules.**]**

Sec. 2. This act shall take effect from its passage.

HS ***Committee Vote:*** Yea 17 Nay 1 JF

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact: See Explanation Below

Affected Agencies: Department of Social Services

Municipal Impact: None

Explanation

State Impact:

This bill repeals the language that required the Commissioner of the Department of Social Services (DSS) to limit reimbursement to medical providers for coinsurance and deductible payments for individuals eligible for both Medicaid and Medicare. The state began limiting this reimbursement during FY00, and it is estimated that this effort reduces Medicaid expenditures by $25 million to $30 million annually.

It is unclear what the effect of this bill would be as the statutory language authorizing the reimbursement of coinsurance and deductibles by DSS remains permissive. Therefore, unless there is affirmative action by the General Assembly to appropriate additional funds for this purpose, it is likely that DSS would not reinstate these reimbursements. Neither the House nor Senate version of sHB 5217, the Appropriations Act, contains funding to reinstate these payments.

OLR Bill Analysis
HB 5532

AN ACT REINSTATING MEDICAID FUNDING FOR DUALLY-ELIGIBLE PATIENTS.

SUMMARY:
This bill eliminates a requirement that the Department of Social Services (DSS) commissioner limit what she pays for coinsurance and deductibles to medical providers who serve people eligible for both Medicaid and Medicare ("dually-eligible") to ensure that the combined Medicare and Medicaid amount is no more than the Medicaid rate. As a practical matter, it eliminates the statutory limit on the amount of co-payments or "crossover" payments DSS pays providers whose patients are Qualified Medicare Beneficiaries (QMBs). Currently, Medicare pays providers 80% of the "allowed" amount for the service and the Medicaid program, through DSS, generally pays the difference, if any, between what Medicare pays and the amount that DSS would pay for someone who is eligible only for Medicaid. (It is not clear whether the absence of these limits in statute will result in higher payments to providers, see COMMENT).

EFFECTIVE DATE: Upon passage

BACKGROUND

QMB, Medicaid, and the Balanced Budget Act

The federal QMB program is one of several dually-eligible categories of Medicaid eligibility for low-income individuals who also qualify for Medicare. It is available to individuals who are eligible for Medicare Part A benefits (hospital and short-term nursing home care) whose incomes do not exceed 100% of the federal poverty level (currently $8,350 annually for one person, after certain income disregards are taken), and whose assets do not exceed $4,000 for an individual, and $6,000 for a couple (200% of the Supplemental Security Income asset

limits). QMBs may be eligible for full Medicaid or may have Medicaid eligibility limited to payment of Medicare Part A and Part B premiums and cost-sharing (deductibles and co-payments) for Medicare services they receive.

Section 4714 of the federal 1997 Balanced Budget Act (BBA) was enacted to give states more flexibility in establishing the amount they pay for Medicare cost-sharing in the QMB program. While previous federal law seemed to give states the option of either limiting what they paid to the difference between what Medicare actually paid (80% of the allowed amount) and the Medicaid rate, or paying the difference between what Medicare paid and the Medicare allowed amount (*i.e.*, the remaining 20%), some federal courts said states had to pay the full 20%. Thus, the BBA made it clear states could limit the co-payments so that the combined payments were no more than the Medicaid rate.

The original state enabling legislation was passed in 1991 (PA 91-8, June Special Session), but it was not until the passage of the 1999 state budget, SA 99-10, that the change was implemented. The legislature removed $54 million from DSS's FY 1999-00 budget to reflect the anticipated savings from reducing or eliminating the co-payments. (The limit on co-payments did not apply to payments to ambulance providers whose maximum public rates the Department of Public Health set.)

For example, before the BBA change, a QMB would have a medical procedure and the provider would bill Medicare $120. Medicare would determine what it considered to be an allowable amount for that procedure ($100) and then pay the provider 80% of that amount ($80). Then, Connecticut's Medicaid program paid the remaining 20% of the allowed amount ($20). Under the BBA, DSS compares the Medicare payment to the amount that it would pay a Medicaid-only provider for the same service. If Medicaid would have paid less than $80 for the service, DSS would pay the provider nothing; if it paid more, DSS would pay the difference, but no more than $20.

COMMENT

Lack of Direction Regarding Co-Payments

By removing the co-payment limits, the law will be silent on how much DSS should pay providers. Federal law allows states to either pay the full 20% or only up to the Medicaid rates, thus the DSS commissioner would probably have the discretion to choose one payment method over another.

COMMITTEE ACTION

Human Services Committee

Joint Favorable Report
Yea 17 Nay 1